Statement of

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Fighting Meth in America's Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies

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Chairman Souder, Vice Chair McHenry, Ranking Member Cummings and Members of the Committee, thank you for the opportunity to appear before you today to discuss the problem of methamphetamine in America and specifically its effect on child welfare services.

I am the Director of Children and Family Futures, Inc., (CFF) a non-profit policy research firm based in Irvine, California. For the past ten years we have worked on public policy issues regarding children affected by substance use disorders in their families. Our work is primarily focused on children in the welfare and child welfare systems. In addition, in 1994, my husband and I became foster and then adoptive parents to two children who embody many of the issues confronting children of parents with substance use disorders who have been abused or neglected. So, I am also speaking as an adoptive mother of children affected by these issues.

In 2002, CFF was awarded a competitive contract from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to develop and implement the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is funded by both the Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect and SAMHSA and we work with both agencies in that work. However, my testimony today represents my own views and not those of the Federal agencies

There are six points I'd like to discuss today, including a list of suggested actions:

1. A review of data on the impact of parental substance use disorders on child welfare agencies and the specifics that are known about methamphetamine;

2. The various ways that children are affected by parents with substance use disorders;

3. The unique characteristics of methamphetamine users that pose new challenges to child welfare organizations;

4. Data regarding the effectiveness of treatment for women with methamphetamine use disorders;

5. Models of effective child welfare and substance abuse services; and

6. Recommendations for action – what can be done to address these issues

1. The impact of parental substance use disorders on child welfare agencies and the specifics about methamphetamine

As noted in multiple sources, the number of methamphetamine users has increased over the past several years and spread from the West throughout the Midwest, now increasingly reaching the Eastern States. In 2003, according to the National Survey of Drug Use and Health, there were 607,000 persons reporting methamphetamine use in the prior 30 days; methamphetamine users now exceeds the number of current crack users (604,000). However, there remains a much larger number of current cocaine users at 2.281 million.[1]

Despite the number and relatively rapid increase in methamphetamine use across the nation, the population of children in out-of-home care in the country has been on a steady decline since 1999 with 523,000 children in care in 2003. The decrease comes after a decade in which the number of kids in care doubled from 276,000 children in 1985 to a high of 570,000 in 1999.

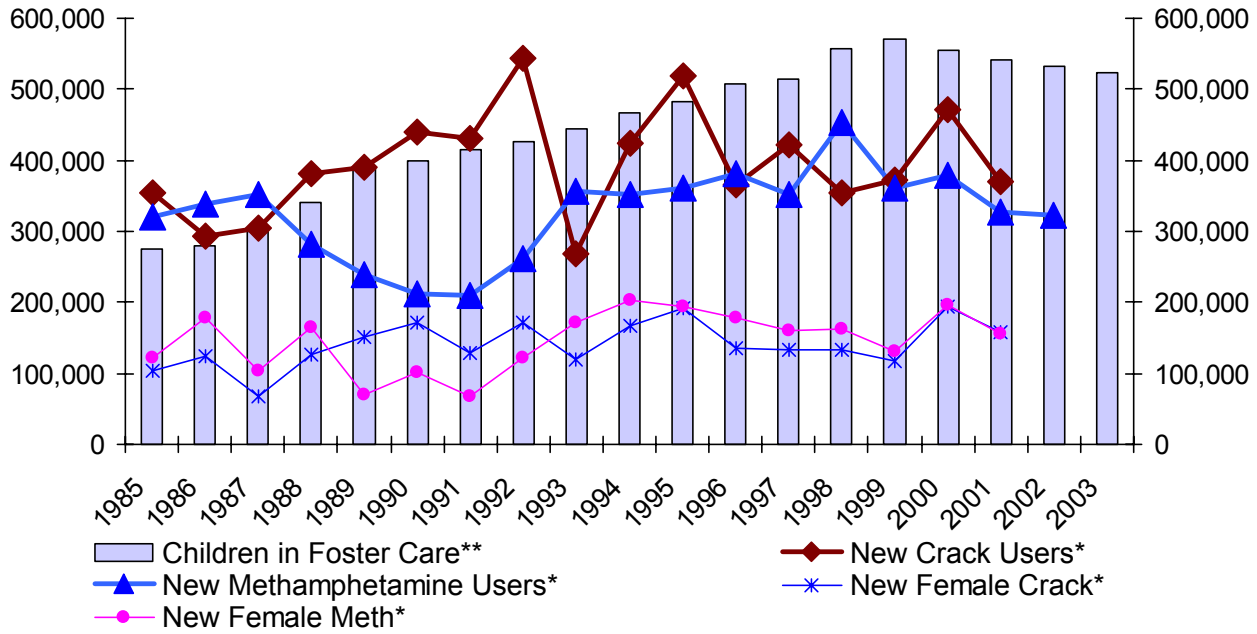
However, there is very little data on the number of children in foster care due to parental substance use disorders. Anecdotal estimates range from 40 to 80%. The Department of Health and Human Services (DHHS) in its Report to Congress in 1999[2] stated that between one-third and two-thirds of children in the child welfare system are affected by substance use disorders.

More recently, DHHS has sponsored the National Study on Child and Adolescent Well-Being (NSCAW) which has collected data on families affected by substance abuse and dependence. Preliminary results found much lower rates of parents needing substance abuse assessments (approximately 25%) and those that were alcohol or drug dependent (about 5%). However, they also found that child welfare workers misclassified parents regarding their need for an assessment and those that were alcohol or drug dependent nearly 80% of the time.[3]

Graph 1 on the following page shows the population of kids in care on September 30 of each year. This is overlaid with the line graphs showing a leading indicator of the cocaine and methamphetamine epidemics—new users of the substance during the year. The number of children in foster care increased by 50% between 1986 and 1992; these are also the peak years of the crack epidemic. Many have attributed this rapid increase of kids in care to the cocaine and crack epidemic of the late 1980s and early 90s.

At this point, we have not seen a similar trend in child welfare caseloads, despite the number of new users of methamphetamine. However, the number of new users who are women is disturbing. This is clearly one of the issues that child welfare has had to address—the large number of women who are using methamphetamine. The issues specific to women and methamphetamine are discussed below.

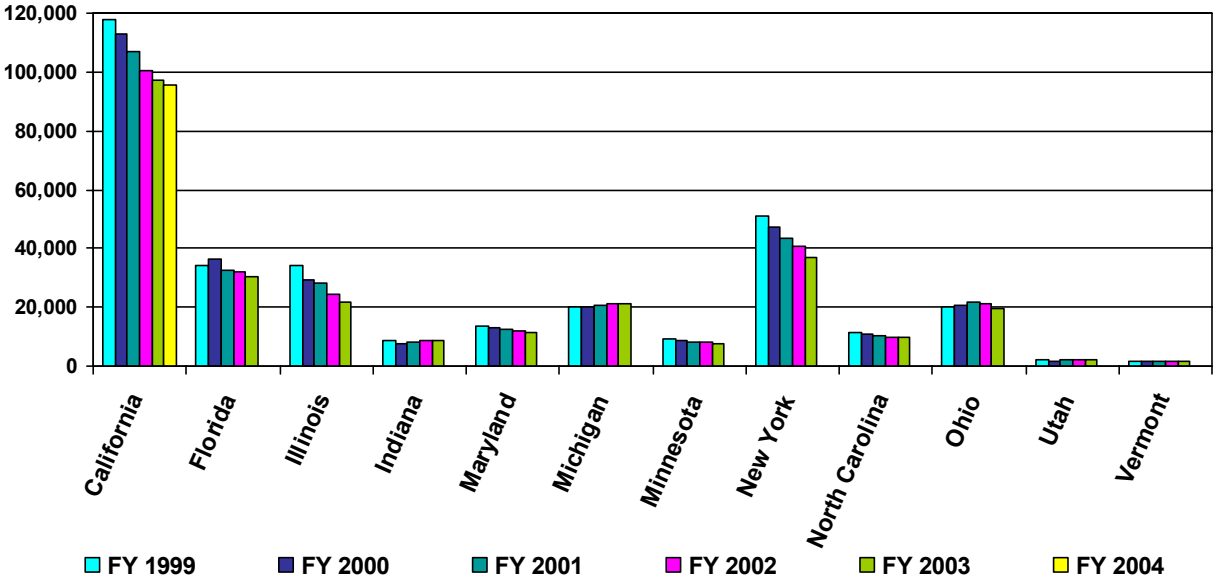
Graph 1: Foster Care Population and Persons Who First Used Crack or Methamphetamine in Prior Year[4]



*All persons age 12 and over

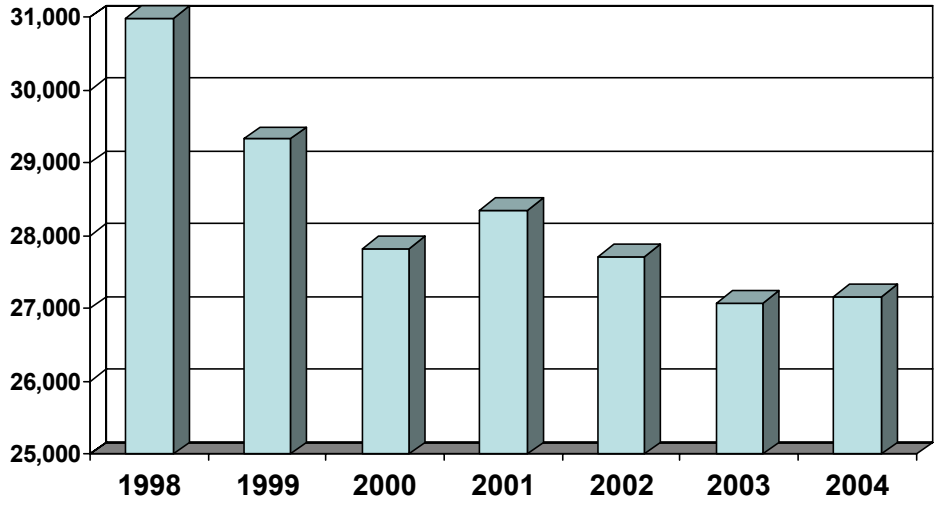
These data show a decrease in the foster care population that is also evident when we look at specific states. Graph 2 shows the last four years of the foster care population in the 12 states that are represented by members of the subcommittee. Of these States, California, Illinois and New York have experienced dramatic reductions in the number of children in out-of-home care. While some of the States may just be beginning to experience the impact of methamphetamine, clearly California has felt the impact of methamphetamine for a decade, and yet they have continued to see an overall reduction in children in care.

Graph 2: Foster Care Population on September 30 of each Fiscal Year in Selected States[5]



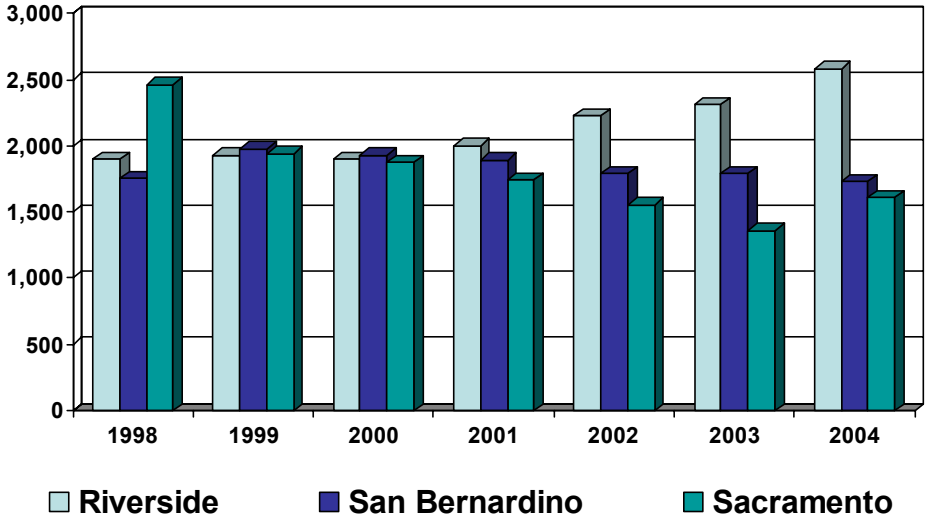
In California, this reduction reflects both fewer children coming into care and more children exiting care over the past six years. Graph 3 shows the decreasing number of children entering care in California (among children who stayed in care for five or more days) with a leveling of that number between 2003 and 2004. So while California has been faced with the increasing number of persons using and dependent on methamphetamine for a decade, through 2004, they have not experienced an overall increase in children being removed from their parents' custody.

Graph 3: Entries to Out-of-Home Care in California[6]



Yet we know that the impact of specific substances and child welfare practice regarding parental substance use can vary greatly from State to State and county to county. For example, Graph 4 shows three California counties that have been discussed in the media as having been particularly affected by methamphetamine production; as the chart shows, they have very different patterns of children entering care.

Graph 4: New Entries to Foster Care: Riverside, San Bernardino and Sacramento Counties[7]



While we haven't seen overall increases in children in out-of-home care, we lack the data to know if there are increases in children who are coming into care affected by substance use, and we do not have data on children specifically affected by methamphetamine. However, the data showing differences at the local level suggest that local child welfare practice plays a role in the number of children entering out-of-home care associated with parental methamphetamine use.

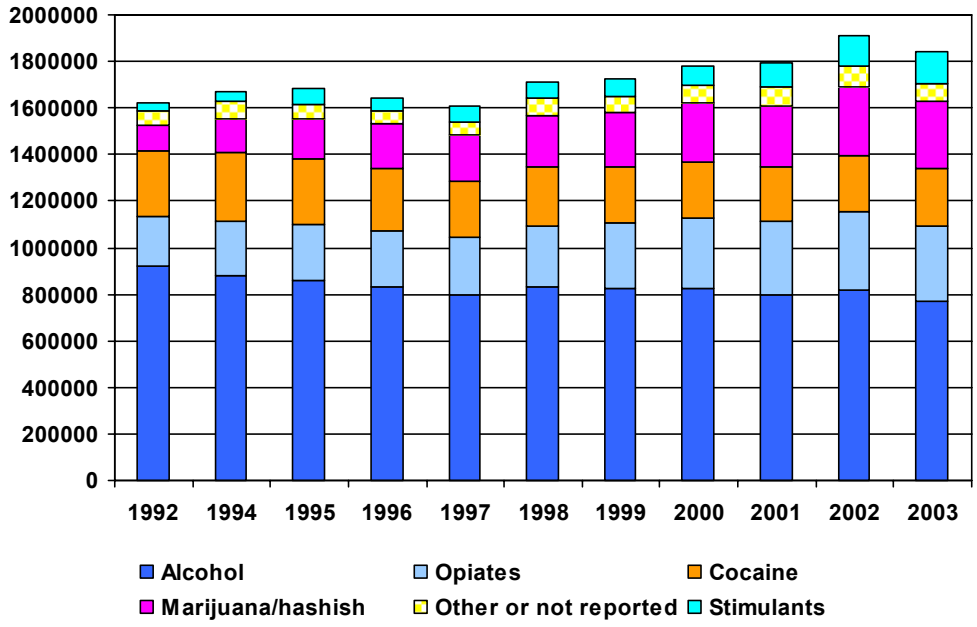
Methamphetamine and Treatment Admissions

Another way to explore these issues is to look at an indicator that would be considered a "lagging" indicator of drug use patterns—those persons entering publicly-funded substance abuse treatment.

Graph 5 shows the number of persons reported by the States entering treatment by primary substance. The data for stimulants (the top of the bar) includes both methamphetamines and other stimulants (other stimulants account for approximately 1% of the admissions). While overall treatment admissions have increased by 14% between 1993 and 2003 (1.618 million to 1.842 million), admissions for person with stimulant disorders increased from 28,900 in 1993 to nearly 137,000 in 2003, a 373% increase.

Just as child welfare has needed to adjust their practices to work with families affected by methamphetamine, substance abuse treatment agencies have needed to adjust to treating methamphetamine users in larger numbers. However, admissions for methamphetamine account for only about 7% of all admissions. Despite the increase in methamphetamine, one might assume that child welfare practitioners are still working with many more families affected by the other substances of abuse, particularly alcohol which accounts for more than 40% of treatment admissions.

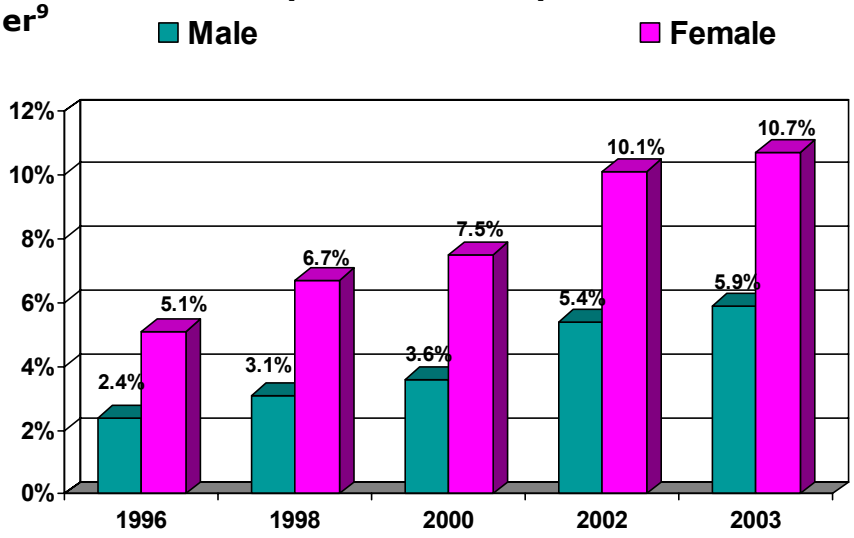
Graph 5: Treatment Admissions by Primary Substance[8]



Methamphetamine Users Differ from Others with Substance Use Disorders

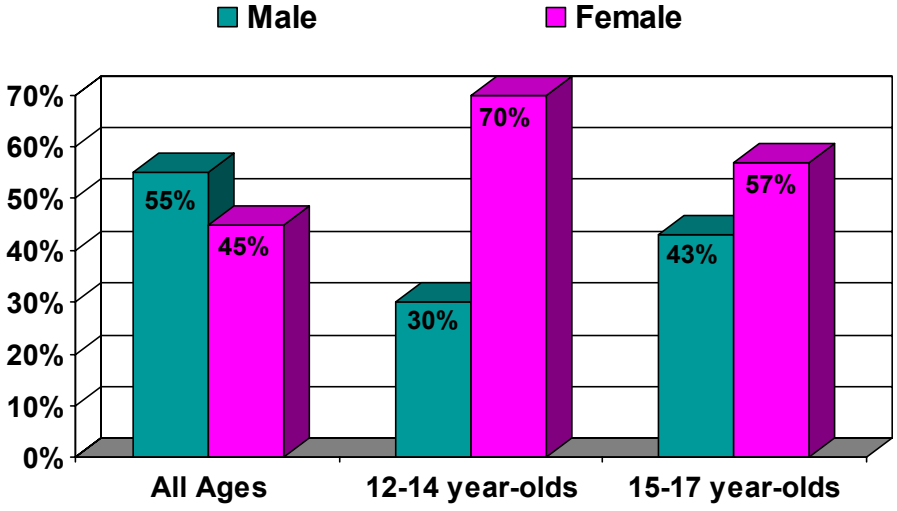
Child welfare unquestionably faces unique characteristics of persons in treatment for methamphetamine. In the nation, women represent about 30% of all treatment admissions. However, women's admissions for methamphetamine are much higher percentage of their overall admissions than for men. Of admissions for methamphetamine related problems, women are just over 10% of their total admissions compared to 6% of admissions for men. Graph 6 shows the treatment admission data by gender.

Graph 6: Percent Methamphetamine/Amphetamine as Primary Substance, By Gender[9]



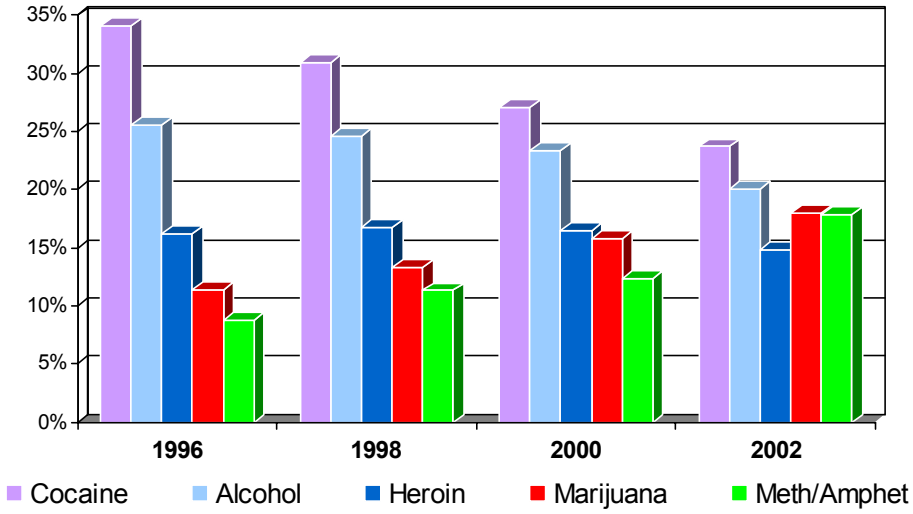
Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents, with girls representing 70% of youth admitted to treatment for methamphetamine between 12 and 14 year olds. Graph 7 shows these data.

Graph 7: 2002 Methamphetamine/Amphetamine Admissions by Gender and Age[10]



Another urgent issue is the change in drug use patterns among pregnant women. Graph 8 shows that among pregnant women entering treatment, there has been a decrease in those reporting cocaine and alcohol-related problems, relative stability in admissions for heroin and an increase of 57% for marijuana and of 105% for pregnant women reporting methamphetamine disorders.

Graph 8: 2002 Treatment Admissions for Pregnant Females by Percent reporting Primary Substance[11]



Summary

The number of children coming into the foster care system has declined over the last half decade. However, child welfare practice and substance use patterns vary from State to State and county to county. While data on the number of children affected specifically by methamphetamine is not available, we know that treatment admissions for methamphetamine are a small yet growing group among those entering treatment in most areas of the country.

The lack of child welfare-specific data on substance use disorders reinforces the long-standing issue that child welfare workers need better protocols for screening, better cross-system linkages to assessments and importantly, better information systems to monitor this type of emerging issue. Our data on this problem are surprisingly sparse, given the importance attached to this issue. The federally mandated child welfare information system produces only optional data on substance abuse or dependence; in many states, this is not a field that is required to be filled out.

As we have seen, the impact of methamphetamine as it affects children and parents in the child welfare system must be compared with the total pattern of drug use and the need for treatment across all legal and illegal drugs that affect children. In the last graph, the rise in methamphetamine is unmistakable, but so is the fact that the total of the other four drugs is far greater than the number of children affected by methamphetamine.

2. Ways in which children are affected by parents with substance use disorders

Children of parents with substance use disorders may experience multiple risks to their safety and well-being. These risks have been well documented and include:

- Chronic neglect
- Chaotic home lives
- Violence associated with drug sales
- Inconsistent parenting
- Entry to foster care and multiple placements
- Incarcerated parent(s)
- May be risk of HIV exposure if parent is a needle user

In addition to these risks, it is particularly important for child welfare to understand the types of parental methamphetamine use that affect children. There are six situations in which children are affected by their parent's involvement in methamphetamine:

- The parent uses or abuses methamphetamine (episodic use)
- The parent is chemically dependent on methamphetamine
- The mother uses methamphetamine while pregnant with the child
- The parent "cooks" methamphetamine in the home
- The parent sells, transports, or distributes methamphetamine (traffickers)
- The parent manufactures large quantities of methamphetamine (superlabs)

While much of the media attention and child welfare training has been focused on parents who "cook" methamphetamine, each situation presents specific risks and dangers for the child and specific concerns for the child welfare worker. As Jay Wurscher, the substance abuse program manager for the Oregon Department of Children and Families, stated, "The Oregon workers started out being trained, largely by the criminal justice system, to address issues related to methamphetamine manufacturing. What they found over time was that workers had to be much more prepared to work with families with methamphetamine abuse and dependence and that the number of times that workers confronted actual manufacturing was rare in their practice compared to the number of families affected by methamphetamine abuse and dependence."[12] Each separate situation confronting child welfare in their need to differentiate the risk to children is discussed below.

Parents Who Use or Abuse Methamphetamine

Episodic parental use or abuse of methamphetamine is the most common means by which children are affected by parental methamphetamine use. This method of exposure accounts for the highest number of children exposed to methamphetamine, compared to the numbers found in the other categories.

Similar to parents who abuse other substances, particularly stimulants such as cocaine, parents under the influence of methamphetamine pose a danger to their children. When "high," the parent may exhibit poor judgment, confusion, irritability, paranoia, and increased violence; they may fail to provide adequate supervision. Even during periods in which the parent may not be actively under the influence, the family and social environment may be inadequate, and the children may be at risk of abuse and neglect due to the family dynamics associated with substance use.

In households where a family member smokes the substance, children may be exposed to secondhand methamphetamine smoke. They may accidentally ingest the substance if it is kept in the home.

Because methamphetamine users typically use other substances at the same time, including alcohol, tobacco, and other drugs, the risks to their children accumulate, and it becomes difficult to attribute a particular effect to a particular substance.

Dependent Parents

When the parent is substance dependent, meaning they meet criteria for a diagnosis of substance dependence rather than a substance abuser or user, chronic neglect of the children becomes more likely, and the family and social environment is more likely to be inadequate. The children are exposed to the drug-affected parent more frequently and for longer periods of time. They may be living in inadequate conditions, lacking food, water, gas, and electricity. They may lack medical care, dental care, and immunizations. These children are also at greater risk of abuse. Some researchers have found persons with methamphetamine dependence to have an increased association of drug use and high risk sexual behaviors[13] which may place children at higher risk of childhood sexual abuse than children of parents with other substance use disorders.

Prenatal Exposure

Many studies of the effects of prenatal substance exposure compare methamphetamine-exposed infants to non-exposed infants without also comparing them to cocaine-exposed or other stimulant-exposed infants, so it is not known whether the effects are associated with methamphetamine in particular or with all stimulants.

The direct (when chemicals enter the fetus' blood system) and indirect effects (the decrease in blood flow to the fetus as a result of decreased blood from the mother)[14] of substances, including the legal drugs, tobacco and alcohol, can cause birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders. Methamphetamine and other stimulants jeopardize the development of the fetal brain and other organs.[15] As was previously found with crack cocaine exposure, a high dose of methamphetamine taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus, which can lead to stroke or brain hemorrhage.[16] Prenatal stimulant exposure has

been associated with difficulty sucking and swallowing, and hypersensitivity to touch after birth.[17]

Stimulant-exposed children are often affected by other substances used by the mother, and by environmental risk factors such as the mother's nutritional and health status. The cumulative effects of the use of multiple substances and other environmental risk factors have significant adverse effects on the newborn. These effects may be greater than the effects of stimulant use alone.[18] Substances such as alcohol have severe long-term effects on prenatally-exposed children. Children with Fetal Alcohol Spectrum Disorders (FASD) exhibit a range of central nervous system effects, including mental retardation;[19] hyperactivity and attention deficits;[20] poor impulse control; perceptual and motor problems;[21] expressive language delays;[22] delayed motor development;[23] poor listening skills;[24] poor abstract thinking skills; poor problem-solving skills; poor social adaptation; and deficits in attention and memory.[25]

Thus the most significant forms of substance use during pregnancy may be the use of alcohol and tobacco, given the total number of children affected, the severe central nervous system impairments that can result from alcohol exposure, and the low birth weight associated with smoking. Many of the central nervous system-related disorders are determined in the first trimester of pregnancy. Recent surveys indicate that far too many women are using substances during the early months of pregnancy. Table 1 shows the percentage of pregnant women reporting substance use. The number of infants is derived from that percentage and the 4.1 million annual births in the country.[*] Clearly the message regarding alcohol use and pregnancy has reached women with substantial declines in binge alcohol use by the third trimester. Yet there is a continuing urgency to reduce substance use during pregnancy, particularly in the first trimester.

Table 1: Substance Use during Pregnancy[26]

Substance Used (Past Month)	**1st Trimester**	**2nd Trimester**	**3rd Trimester**
Any Illicit Drug	7.7% women 315,161 infants	3.2% women 130,976 infants	2.3% women 94,139 infants
Alcohol Use	19.6% women 802,228 infants	6.1% women 249,673 infants	4.7% women 192,371 infants
Binge Alcohol Use	10.9% women 446,137 infants	1.4% women 57,302 infants	0.7% women 28,651 infants

It seems critical to do rapid, in-depth studies at several key points throughout the nation, including prevalence studies in hospitals that can be done with random screening, as Idaho, Hawaii, and Monterey County, California have done in recent

[*] Note: for purposes of this paper, it is assumed that the pattern of drug use among all pregnant women is the same as among those who actually gave births to live children, although live births were 63.4% of all pregnancies in 2000, due to miscarriages and terminations.

years. This would add to our total store of information on the drugs of choice of parents who prenatally expose their infants to harmful substances. These studies have not been done nationally and *the last representative State-level study monitoring prenatal substance exposure was in California in 1992*.

Home Labs

Some parents produce quantities of methamphetamine in their homes for their own use or small-scale distribution, as compared with the superlabs where large-scale production occurs. Children in these homes are subject to the same risks noted in the sections on parents who use/abuse and are dependent on the drug, but they have additional risks associated with the substances used in the production of methamphetamine and the method of production. The children may be exposed to toxic chemicals, contaminated food, fumes released during the "cooking" process, and the danger of fire or explosion from the manufacturing process.

The risks to children and to "first responders" including child welfare workers in homes where methamphetamine is produced have been well documented. These risks include toxic chemical exposure. Children are more likely than adults to suffer health effects from exposure to chemicals. They have higher metabolic rates; their skeletal systems and nervous systems are developing; their skin is not as thick as an adult's skin, which means they absorb chemicals faster; and children tend to put things in their mouths and use touch to explore the world. Some fumes or gases are heavier than air, and will sink down to the child's level, increasing their exposure. Children also tend to imitate adult behavior and are vulnerable in chaotic and unsafe environments.[27] A review by Kolecki[28] revealed that pediatric patients with methamphetamine poisoning exhibited rapid heartbeat, agitation, inconsolable crying, irritability, and vomiting.

Trafficking

Parents who traffic in methamphetamine by selling, transporting, or distributing it, expose their children to an increased risk of violence and abuse. There may be weapons in the home. The parent's associates or customers may carry weapons, putting the children at risk for violence. These children are also at increased risk of physical and sexual abuse by those who visit the home.

Superlabs

Superlabs are methamphetamine laboratories where methamphetamine is produced on a large scale (estimated at 10 pounds per day). Children are sometimes found in these superlabs, but they are less likely to be present in superlabs than in the homes where smaller quantities are produced.

Number of Children in Methamphetamine Homes

Table 2 shows the number of children reported to be involved where methamphetamine was being manufactured.

Table 2: Children Affected in Methamphetamine Manufacturing[29]

	2000	2001	2002	2003	Cumulative Total
Number of Incidents	8,971	13,270	15,353	14,260	51,854
Incidents with children present	1,803	2,191	2,077	1,442	7,513
Children residing in labs	216	976	2,023	1,447	4,662
Children affected**	1,803	2,191	3,167	3,419	10,580
Children exposed to toxic chemicals	345	788	1,373	1,291	3,797
Children taken into protective custody	353	778	1,026	724	2,881
Children injured	12	14	26	44	96
Children killed	3	0	2	3	8

*The 2003 figure for the number of incidents is calendar year, while the remaining data in the column are for fiscal year; **Data for 2000 and 2001 may not show all children affected

Between 2000 and 2003, more than 10,000 children have been affected by methamphetamine manufacturing. These figures are probably underreported, since many states do not keep records on children present at laboratory sites, nor do they medically evaluate the children for the presence of drugs or chemicals. While these children are critical, it is important for child welfare to consider these numbers in the context of the much larger number of children entering child welfare services affected by parental substance use disorders. As shown above in Graph 1, there are over 500,000 children in out-of-home care and approximately 250,000 children enter care each year. *During the four year period in which 10,000 children were reported as affected by methamphetamine, 1 million children entered out-of-home care.*

Summary

Children are affected by parental methamphetamine use in a variety of ways. Clearly more children are affected by parents who use, abuse and are dependent on methamphetamine than those who might be affected by manufacturing activities. However, it is important for child welfare workers to understand which group of children they are working with and to include screening and assessment for substance use in the child risk and safety assessments. It is a sad reality, as borne out by some of this data, that screening and assessment practices are still inadequate to detect most of the prenatal and post-natal substance use affecting children in the child welfare system.

It is also critical, given these effects on children, to take seriously the new requirement in the 2003 amendments to the Child Abuse Prevention and Treatment Act that require all substantiated child abuse and neglect be reported to the local agencies responsible for the Individuals with Disabilities Education Act (IDEA). Developmental delays and disabilities resulting from these prenatal and post-natal effects must be the focus of the earliest possible interventions, since we have extensive evidence that early intervention can address some of the most serious of these developmental effects.

3. The unique characteristics of methamphetamine users that pose new challenges to child welfare organizations

To provide a perspective on challenges facing child welfare regarding methamphetamine use, it is helpful to compare methamphetamine users with the users of cocaine, another stimulant that has been a child welfare issue for the past two decades. Compared with cocaine users, methamphetamine users:

- Begin using substances at a younger age[30]
- Enter treatment at a younger age[31]
- Are more likely to use multiple drugs (especially marijuana)[32]
- Have a higher frequency of use[33]
- Are less likely to use alcohol[34]
- Report feeling less "addicted" than cocaine users[35]
- Are more likely to use methamphetamine continuously throughout the day at evenly spaced intervals and consistently over time, rather than concentrating use in the evening as cocaine users tend to do[36]
- Use fewer times per day than cocaine users (though the same amount of drug is used)[37]
- Spend less money to purchase the drug[38]
- Are more likely to be female and Caucasian[39]

In addition, several sources have documented the rural nature of methamphetamine use.[40] While over 20 million Americans who needed treatment for substance use disorders in 2003 did not receive it, access to treatment resources in rural communities is a critical issue for child welfare practice.

Women Methamphetamine Users

Of the total number of individuals admitted to treatment for methamphetamine, 47% are women. This percentage of female admissions is higher than the percentage of female admissions associated with any other drug except tranquilizers.[41] The implication is that more children are likely to be affected by a parent's use of methamphetamine than if users were predominantly male, since caretakers are often predominately female.

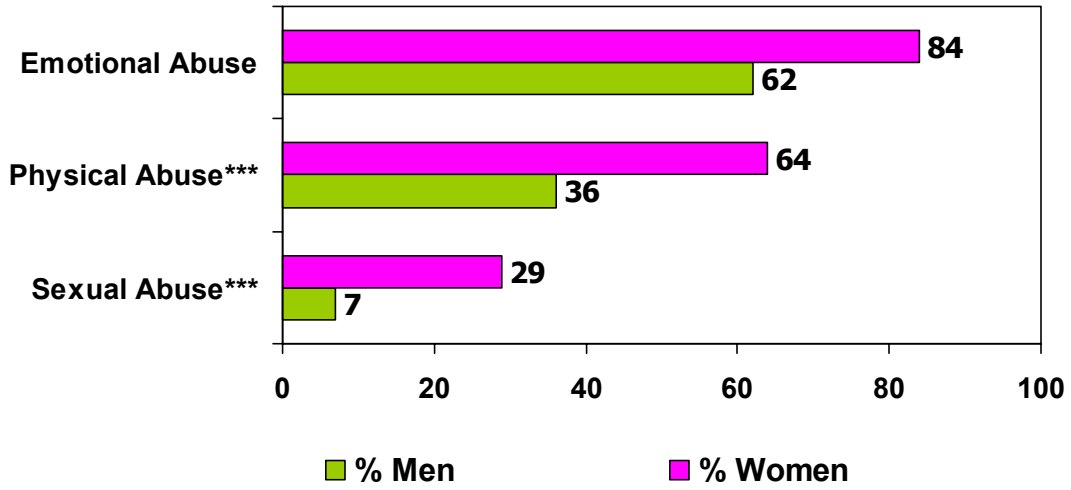
Compared with male methamphetamine users, female methamphetamine users:

- Use methamphetamine more days in a 30-day period[42]
- Smoke rather than snort or inject the drug[43]
- Are more likely to be single parents who live alone with their children[44]
- Have worse medical, psychiatric, and employment profiles[45]

These statistics indicate a greater risk for the children of mothers who use methamphetamine. The parent is likely to use the drug more often and have greater difficulty providing adequate parenting and economic support for the child.

Methamphetamine users, like other drug users, are more likely than non-users to have experienced physical or sexual abuse as children. A recent study of clients of a publicly-funded treatment system found that two-thirds of women methamphetamine users had been physically abused and nearly one-third had been sexually abused. The women were victims of this abuse at a very young age with 43% reporting that sexual abuse occurred before the age of 10 and a similar percentage reported childhood physical abuse.[46] The data on types of childhood abuse are shown in Graph 9.

Graph 9: Childhood Abuse among Adult Methamphetamine Clients in Treatment



***** significant difference between women and men p < .001**

This information has crucial impact on child welfare. First, the majority of women that are mothers of children in care may have significant co-occurring mental disorders associated with their childhood abuse, including a high degree of post-traumatic stress associated with this childhood trauma. Second, these data point to the critical need for substance abuse prevention programming targeted to the children who are victims of child abuse and are in the child welfare system today.

The issues specific to women methamphetamine users also suggest a further need for training of child welfare workers in effective treatment engagement strategies, for improved screening and assessment, for child welfare information systems and drug treatment admission information systems to both be upgraded to capture this information, and a need for expanded outreach to rural areas, using formal and informal means of providing services to rural areas.

4. Information regarding the effectiveness of treatment for women with methamphetamine use disorders

Despite these complex clinical issues and co-occurring disorders among women with methamphetamine dependence, studies have shown that treatment for methamphetamine can effective. As the committee is aware, the University of California at Los Angeles, Integrated Substance Abuse Program has conducted extensive research on treatment for methamphetamine. They have found that outcomes have not differed from other drugs of abuse treatment studies.

Positive treatment outcomes were achieved using:

- Intensive outpatient setting
- Three to five visits per week of comprehensive counseling for at least the first three months
- Cognitive behavioral approaches
- Contingency management
- Reducing consequences associated with drug use such as the need for health care, employment services and mental disorders
- Motivational interviewing & brief intervention models
- Intervening earlier and reducing cumulative harm
- Attending to co-occurring mental disorders.

Brecht[47] has analyzed the treatment effectiveness data from UCLA specifically to document treatment outcomes for women. She found positive outcomes regarding substance use among women in treatment and outcomes that are comparable to other substances of abuse. For every 10 women entering treatment, 6 were continuously abstinent for 1 month; 4 were continuously abstinent for 12 months; 3 were continuously abstinent for 24 months and 3 continued to be abstinent at 48 months. This standard is a fairly high standard to meet—continuous abstinence for 48 months.

5. Models of effective child welfare and substance abuse services

Counties and States around the country have begun the hard work of providing comprehensive programs and system reforms to better address the issue of substance use among families in child welfare. For example, positive outcomes regarding methamphetamine dependence among parents in child welfare have been documented in Sacramento County. Over the past decade, Sacramento has instituted six critical system changes in child welfare and treatment practices for parents with substance use disorders. The system changes require a comprehensive view of the county's response to substance use disorders among families in child welfare. Sacramento's system changes include:

1. **Comprehensive training—**to ensure that all workers in the Department of Health and Human Services fully understand substance abuse and dependence and are trained with skills to intervene with parents

2. **Early Intervention Specialists—**Social workers trained in motivational enhancement therapy are stationed at the family court to intervene and conduct preliminary assessments with *ALL* parents with substance abuse allegations at the very first court hearing in the case

3. **Improvements in Cross-System Information Systems**—to ensure that communication across systems and methods to monitor outcomes are in place as well as management of the county's treatment capacity

4. **Prioritization of Families in Child Protective Services**—County-wide policy to ensure that families in the child welfare system have priority access to substance abuse treatment services

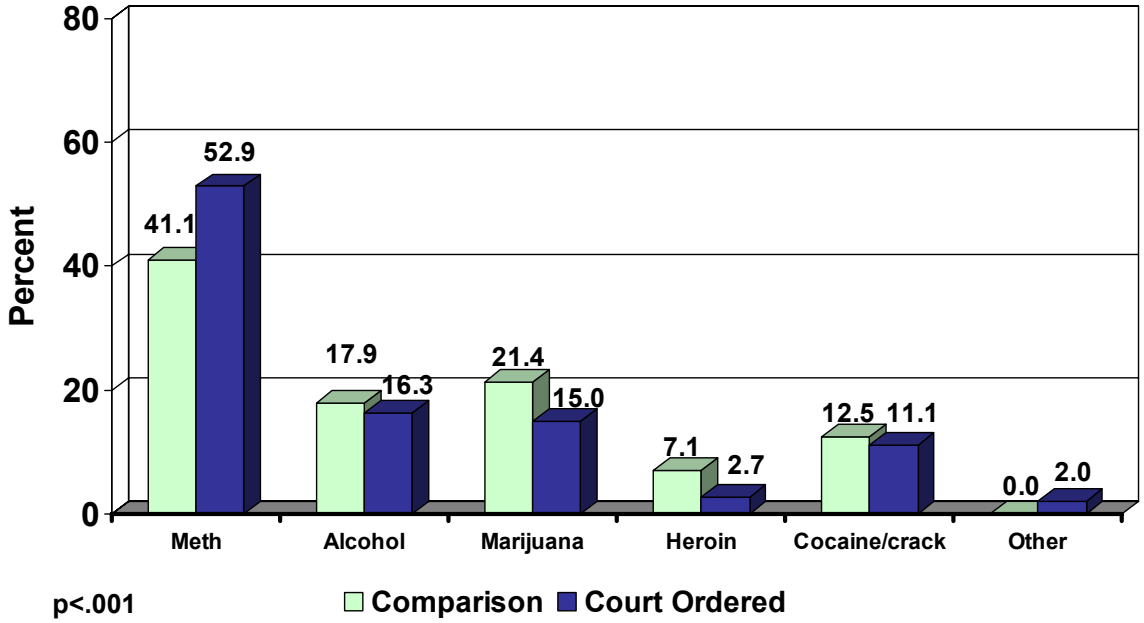
5. **Specialized Treatment and Recovery Services (STARS)**—provides immediate access to substance abuse assessment and engagement strategies conducted by staff trained in motivational enhancement therapy. STARS provides intensive management of the recovery aspect of the child welfare case plan and routine monitoring and feedback to CPS and the court

6. **Dependency Drug Court**—provides a system of more frequent court appearances for *ALL* parents with allegations of substance use with immediate rewards and sanctions based on compliance with court orders regarding the recovery plan.

These strategies have produced dramatic reductions in the time that children spend in out-of-home care and cost savings to the county. There are over 900 parents and 1500 children included in the treatment group of evaluation data. At 18 months after the child welfare case opened, 44% of parents had reunified with their children compared to 25% of the comparison group. Of the reunified families, on average the comparison group reunified in 300 days and the treatment group reunified in 257 days—cutting nearly two months in costs of out-of-home care.

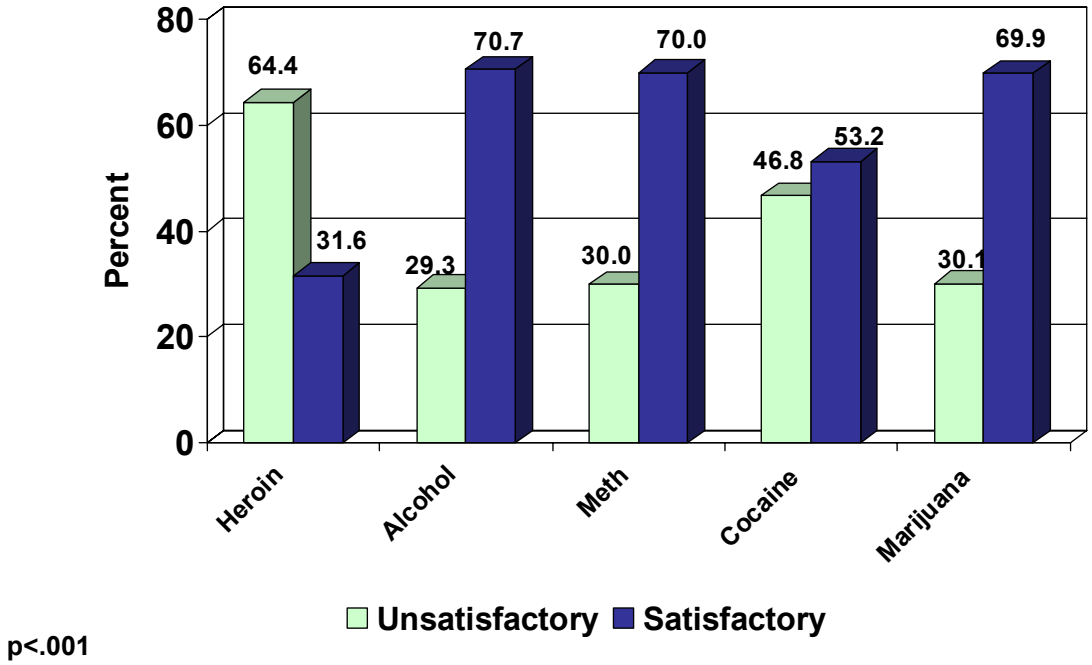
Graph 10 shows the primary substance for two groups of people in treatment, those who were court-ordered and a comparison group who were not court-ordered.

Graph 10: Primary Drug Problem



Positive treatment outcomes have been achieved across groups of drug users as shown in Graph 11.

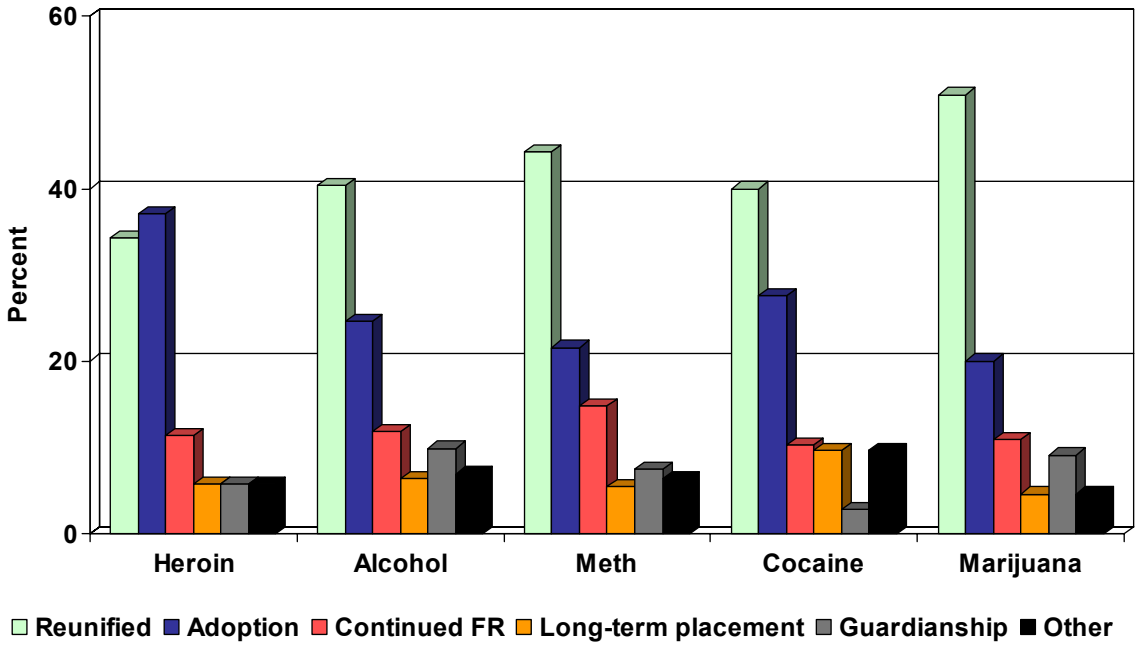
Graph 11: Treatment Discharge Status by Primary Drug Problem



p<.001

Finally, outcomes related to child permanency have not varied by the type of substance used by the parent as shown in Graph 12. At 18 months after the child was placed in protective custody, there was no statistical difference between child placement and parent's primary drug problem. Parents with a primary heroin problem had more children who were adopted than had reunified, however. These outcome data include comparison, court-ordered year 1 and 2 cohorts for a total number of participants of 1,063.

Graph 12: 18-Month Child Placement Outcomes by Parent Primary Drug Problem



6. What can be done to address these issues?

The National Center on Substance Abuse and Child Welfare assists States and communities in their efforts to address these issues. We provide guidance for States and communities regarding methamphetamine and child welfare practices, including measuring risk and safety factors for children and child welfare workers who make home visits. We have developed a white paper on methamphetamine and women's and children's issues that is the basis for our guidance to States. We recently presented a 90-minute teleconference on the implications of methamphetamine for child welfare that was attended by grantees of the Children's Bureau System of Care Program, including Federal officials and child welfare workers from around the country. We sponsored "Women, Children, and Methamphetamine, a plenary session at the NASADAD annual conference in June of 2005; we have responded to 30 requests for technical assistance on this issue from national, regional, State, and local jurisdictions; and we compiled a list of internet-accessible resources on methamphetamine and child resources that is available on

the Children and Family Futures website at www.cffutures.org. Our efforts continue, but there is a tremendous amount of work that must be done.

Our recommendations, made throughout this testimony, are not complicated:

- We must have better information on methamphetamine use from both the treatment and child welfare systems—and the two systems need to put their information together so we know about parents and caretakers who are in both systems

- We need better data from hospitals and the maternal and child health systems on the prenatal and at-birth screening they are doing

- We need to continue to invest in better training for child welfare workers so that they can recognize the problems of methamphetamine use among families and ensure timely access to services

- We need earlier diagnosis and intervention with children affected by prenatal and post-natal effects of methamphetamine

- When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the–art, comprehensive, and most importantly to meet the intent of the Adoption and Safe Families Act, interventions must be timely.

Unfortunately, there is all too much that we can learn from the crack and cocaine epidemic experiences of child welfare of the late 1980s and early 1990s. We over-generalized about the problem, and we stigmatized the children involved greatly beyond what we learned they were actually experiencing as a result of prenatal exposure. The phrase "crack babies" was the subject of far too many school workshops that frightened teachers into worrying that these children simply "could not learn." We should not repeat the same mistake with a generation of mis-labeled children who are pre-natally exposed to methamphetamine.

We must, as noted in my testimony, realize how big the methamphetamine problem is—and how big the larger problem is that includes all children and families affected by all forms of substance abuse and dependence, both legal and illegal. Your colleagues in the Congressional caucus on fetal alcohol spectrum disorders have made a large contribution to our understanding of the full range of substance use disorders, and we need to keep that broad perspective in view.[48]

The methamphetamine crisis unquestionably raises new challenges to the child welfare system, and child welfare workers need and deserve help in responding to it. But at the same time, this should not come at the expense of other efforts to help families and communities to deal with the effects of legal and illegal drugs on their children. Helping families and protecting children is not a zero-sum game, in which we must take away from one effort to fund another.

When we worry about our national security, we add resources, and we change our daily routines at airports and in subways, in the interests of security. That is the right thing to do. We don't stop funding the military; we add funding for homeland security as well. The security of thousands of children needs a similarly additive perspective to ensure that timely access to services for parents' recovery and children's safety and well-being can be assured. We can do more, and so we must.

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